

GAO

United States General Accounting Office

Report to the Chairman, Subcommittee
on Military Personnel, Committee on
National Security, House of
Representatives

September 1996

WARTIME MEDICAL CARE

**DOD Is Addressing
Capability Shortfalls,
but Challenges Remain**



GAO/NSIAD-96-224
Report to the Chairman, Subcommittee
on Military Personnel, Committee on
National Security, House of
Representatives

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September 25, 1996

The Honorable Robert K. Dornan
Chairman, Subcommittee on Military Personnel
Committee on National Security
House of Representatives

Dear Mr. Chairman:

As you requested, we determined whether the Department of Defense's (DOD) and the services' efforts to reassess and improve their medical capabilities have been properly focused and coordinated to result in the most effective wartime medical system. Specifically, we reviewed DOD's development, management, and implementation of its Medical Readiness Strategic Plan (MRSP) and the services' medical reengineering efforts. We also examined DOD's ongoing project to identify future wartime medical system requirements.

Background

Operation Desert Storm revealed many weaknesses in medical capabilities of U.S. forces. Subsequent studies conducted by us and the DOD Inspector General revealed shortcomings in DOD's ability to provide adequate, timely medical support during contingencies and problems with the planning and execution of these efforts. The Joint Staff also identified problems with the current design of DOD's wartime medical system. In response to these problems, DOD and the services embarked on initiatives to correct shortfalls in wartime medical capabilities and improve medical readiness. The decisions that emanate from these efforts over the next few years will determine how wartime medical care will be provided for the foreseeable future.

In March 1995, DOD published MRSP to serve as a road map for attaining and sustaining military medical readiness into the 21st century. The Office of the Assistant Secretary of Defense for Health Affairs is responsible for managing MRSP. In developing its MRSP, Health Affairs convened panels of both military and civilian experts to assess medical capability shortfalls in nine functional areas: planning; requirements, capabilities, and assessment; command, control, communications, computers, and information management; logistics; medical evacuation; personnel; training; blood supply; and readiness oversight. For each functional area, the expert panels developed strategic objectives to support the continuum of military operations envisioned in the defense planning guidance for

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fiscal years 1996-2001. A total of 42 action plans were developed to address shortfalls in the 9 functional areas. In assessing these shortfalls, the panels relied heavily on the reports that we and the DOD Inspector General prepared on the medical response during Operation Desert Storm. The panels also identified the offices to be responsible for developing and executing detailed implementation plans.

DOD is engaged in other efforts related to the wartime medical care system. Each service initiated a reengineering program to reassess and reconfigure its wartime medical capabilities to be more compatible with plans for two major regional conflicts and operations other than war. DOD is also trying to forecast the wartime medical demands in the year 2020 and design a military health services system that will be responsive to those demands (known as the MHSS 2020 project). In a separate effort, DOD is also updating an April 1994 study (known as the 733 update) to determine wartime medical personnel requirements for the year 2001.

Results in Brief

DOD and the services are making progress in addressing the medical capability shortfalls that hampered their operations during Operation Desert Storm and other smaller scale operations. MRSP appears to appropriately focus on the medical problems that we, the Joint Staff, and the DOD Inspector General have observed. Although Health Affairs got off to a slow start in managing the implementation process for MRSP, the office has been placing increased emphasis in this area. About 44 percent of the corrective action tasks have been reported as completed. However, Health Affairs does not know whether these actions have corrected the problems. Some corrective action plans have not been submitted, and about 7 percent of corrective action tasks have been reported as behind schedule. Funding may also be an obstacle to implementation, since many key tasks requiring funding are either unfunded or partially funded.

The services' medical reengineering programs are addressing common goals: to be lighter, smaller, more mobile, and adaptable to different mission requirements. The changes arising from these reengineering programs appear to provide significant enhancements to current medical system capabilities. To respond to the mobility problems encountered in Operation Desert Storm, for example, the services are reconfiguring their combat hospitals into smaller components.

Even though DOD's MRSP and the services' reengineering programs are focused on correcting current and near-term medical problems, DOD's MHSS

2020 project has yet to reveal how the future wartime medical system should look. Consequently, it is unknown how compatible the current efforts to improve wartime medical care will be with the future military health services system.

DOD Needed to Improve Its Wartime Medical Capabilities

To respond to the new national military strategy resulting from the end of the Cold War and problems that we, the Joint Staff, and the DOD Inspector General identified, DOD initiated efforts to improve its wartime medical capabilities. Defense planning guidance, modified in May 1994, requires DOD to be ready to engage in two nearly simultaneous major regional conflicts and prepare for smaller scale operations other than war. DOD assumed that future operations would have far shorter warning times and durations than Cold War scenarios.

The transition to the current defense planning guidance, particularly the projected shorter warning times, increased DOD's emphasis on joint service operations and the need to react quickly to a major regional conflict or an operation other than war. This transition has also underscored the need for the services to redesign their wartime medical systems to reduce transportation demands because of limited lift capacity. Medical systems must compete with the movement of combat troops and other war-fighting materials to the theater.

On the basis of war games conducted in December 1994, the Joint Staff determined that the commanders in chief were unable to provide adequate lift capability to move medical logistics and deployable hospitals to support two nearly simultaneous major regional conflicts. The Joint Staff recommended that the services investigate the possibility of evacuating casualties more quickly to the United States for treatment. The Joint Staff believed anticipated conflicts might be of such short duration that it would be unlikely that the soldiers would be well enough to return to duty after treatment in the theater. On the basis of war games completed in March 1995, the Joint Staff also recommended that the services approach medical operations from a joint perspective and redesign their medical systems assuming smaller and lighter deployable hospitals and quicker evacuation of patients to the United States for treatment.

On September 30, 1993, the DOD Inspector General issued a report outlining several wartime medical problems that were consistent with Joint Staff observations.¹ The Inspector General criticized DOD for a lack of

¹Medical Mobilization Planning and Execution, DOD Inspector General (93-INS-13, Sept. 30, 1993).

joint medical planning. The report stated that DOD could not ensure the deployability of medical personnel during contingencies for several reasons, including outdated methods for determining personnel requirements, assignment of personnel to incorrect skill areas, and inadequate training of medical personnel. The report also stated that DOD's deployable hospitals lacked sufficient mobility and had incompatible communication capability that limited their ability to prepare for incoming casualties.

We have issued a series of reports that describe problems in DOD's wartime medical planning and capability to provide wartime medical care.² We found that understaffed and inadequately supplied and equipped medical units in Operation Desert Storm might not have been able to provide adequate care if the predicted number of casualties had occurred. Also, the medical units were not staffed and equipped to provide noncombat care and were unable to support the evacuation of casualties from the combat theater or receive large numbers of chemically contaminated casualties. Other medical force problems included (1) large numbers of nondeployable medical personnel due to unacceptable physical conditions, lack of required skills, and mismatches in medical specialties; (2) a widespread lack of training for the wartime missions; and (3) inadequate or missing equipment and supplies.

In addition, we testified in March 1995 that several key factors, such as the population at risk and wounded-in-action rates, that affect the demand for wartime medical care were still being debated.³ We also stated that reaching agreement on the key factors was critical to arriving at the best wartime medical care system for the future, as it would allow decisionmakers to direct their attention to optimizing the medical care system for that demand. We reported in June 1996 that DOD was still having difficulty reaching agreement on such factors.⁴

²Operation Desert Storm: Problems with Air Force Medical Readiness (GAO/NSIAD-94-58, Dec. 30, 1993); Operation Desert Storm: Improvements Required in the Navy's Wartime Medical Program (GAO/NSIAD-93-189, July 28, 1993); Operation Desert Storm: Full Army Medical Capability Not Achieved (GAO/NSIAD-92-175, Aug. 18, 1992).

³Wartime Medical Care: Aligning Sound Requirements With New Combat Care Approaches Is Key to Restructuring Force (GAO/T-NSIAD-95-129, Mar. 30, 1995).

⁴Wartime Medical Care: Personnel Requirements Still Not Resolved (GAO-NSIAD-96-173, June 28, 1996).

MRSP Appropriately Describes Readiness Problems, but Challenges Remain

Our comparison of problems highlighted by MRSP with those we, the Joint Staff, and the DOD Inspector General had previously identified shows that MRSP appropriately describes medical readiness problems needing resolution. The problems outlined in MRSP are also consistent with the recent changes in the Defense Planning Guidance. For example, MRSP points out that current medical planning is based on Cold War assumptions in which the services planned to fight the former Soviet Union individually rather than jointly. This lack of a joint approach made the DOD medical system unresponsive to the full continuum of anticipated contingencies, including major regional conflicts, peacemaking, and disaster relief. Accordingly, MRSP lists specific tasks Health Affairs, the services, the Joint Staff, and other DOD activities should take to ensure that joint medical planning becomes standard throughout DOD.

MRSP also identifies the need for the services to modernize their deployable hospitals to reduce their weight and size. This reduction will decrease transportation demands and improve the mobility and transportability of such hospitals. It lists steps, such as incorporating technological advancements and equipment modernization, to correct these problems. Similarly, MRSP describes many factors that inhibit the deployability of medical personnel and lists steps to improve the training and certification of medical personnel to ensure they are adequately prepared to perform functions expected of them while deployed.

MRSP outlines corrective actions to address problems in the communications area such as ensuring interoperability and adaptability of individual service medical communication with global communications systems. It also requires specific DOD offices to ensure the availability of critical medical materials needed for a conflict. MRSP also stresses the need for DOD and the services to reexamine and validate the key factors that affect the demand for wartime medical care.

Three additional areas are currently being added to MRSP: nuclear, biological, and chemical warfare; operations other than war; and research and development. For each area, an expert panel identified capability shortfalls and developed corrective actions. Health Affairs plans to add these new areas to MRSP by December 31, 1996.

MRSP Started Slowly

Health Affairs got off to a slow start in monitoring progress being made in correcting medical readiness problems. The primary tool Health Affairs uses to monitor progress is its review of periodic updates of

implementation plans submitted by the responsible offices. These plans summarize how and when a responsible office intends to correct a particular medical readiness problem described in MRSP. Although the implementation plans do not indicate the amount of funding involved, they describe whether specific corrective actions are fully or partially funded or unfunded. MRSP requires 400 implementation plans because of the multiple tasks and multiple offices responsible for carrying out needed actions.

Initially, Health Affairs had difficulty obtaining complete implementation plans in a consistent format from the responsible offices. Although the offices were to submit the plans by the end of June 1995, Health Affairs had not obtained 19 (5 percent) of the required implementation plans as of April 30, 1996. The Joint Staff was responsible for six (32 percent) of the missing plans. A Joint Staff official said that staff turnover and competing priorities delayed the submission of the implementation plans but that they would be completed by the fall of 1996. The other offices responsible for the missing plans were Health Affairs, the Defense Modeling and Simulation Office, and the Office of the Assistant Secretary of Defense for Reserve Affairs. In commenting on our draft report, Health Affairs reported that it had obtained an additional 10 implementation plans, including all of the missing plans from the Joint Staff.

Health Affairs also had difficulty collecting and analyzing the initial submissions because of the volume of information. Health Affairs corrected this situation by developing computer software to facilitate the quarterly updating and analysis of the implementation plans and sharing it with the responsible offices. In addition, Health Affairs entered into a contract with an outside firm to put the implementation plans on a computerized network so the responsible offices could continually keep them updated. This project is expected to be accomplished in December 1996.

As a part of its monitoring efforts, in February 1996, Health Affairs convened most of the experts that helped develop MRSP to determine whether (1) the individual offices given responsibility for correcting medical readiness problems in MRSP were still appropriate and (2) the anticipated corrective actions described by those offices were responsive to the current readiness problems. These panels recommended several changes in both responsibilities and needed corrective actions. If approved, the changes are expected to be made to MRSP in October 1996.

Corrective Actions Are Underway, but Many Are Behind Schedule

Our analysis of the 1,362 specific tasks included in 400 MRSP implementation plans shows that the responsible offices are making progress in correcting medical readiness problems but that some tasks are behind schedule. More specifically, 604 (44.3 percent) of the 1,362 tasks were reported as completed, but 94 (6.9 percent) were reported as behind schedule as of April 30, 1996.⁵ Milestones for completing the remaining 664 tasks have not yet occurred.

During the summer of 1995, the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the services identified the following six plans for priority monitoring: joint medical planning, information management, joint medical logistics and planning, medical evacuation, deployability of medical personnel, and medical readiness oversight. The tasks for the six priority plans and their implementation status are shown in table 1.

Table 1: MRSP Tasks That Were Completed and Behind Schedule for Six Priority Action Plans (as of Apr. 30, 1996)

Action plan	Total tasks	Tasks completed		Tasks behind schedule	
		Number	Percent	Number	Percent
Joint medical planning	29	12	41	2	7
Information management	17	7	41	0	0
Joint medical logistics and planning	52	27	52	4	8
Medical evacuation	29	6	21	1	3
Deployability of medical personnel	6	1	17	0	0
Medical readiness oversight	3	3	100	0	0
Total	136	56	41	7	5

Our analysis is meant to provide a general overview of how the responsible DOD activities view their attempts to correct the medical readiness problems assigned to them without regard to whether one task is more critical than another. Also, the corrective actions may not be directly attributable to the MRSP process; some of the DOD offices responsible for such issues had already undertaken corrective actions. (MRSP does not duplicate these efforts but attempts to consolidate their oversight.)

Several Obstacles May Inhibit Progress

Although progress is being made in implementing MRSP, some potential obstacles may hamper the timely correction of problems noted in the plan.

⁵This date was the last time the implementation plans were updated by the responsible offices.

One of these obstacles involves the three offices (Health Affairs, the Defense Modeling and Simulation Office, and the Office of the Assistant Secretary of Defense for Reserve Affairs) that have not yet submitted detailed implementation plans for corrective actions, which raises questions about whether problems are being addressed. Some DOD officials told us that they were concerned that those offices outside the control of Health Affairs have not given implementation of MRSP the level of attention it deserves. In this regard, the officials believe that MRSP would have been given higher visibility and priority for implementation if it had been published with the signature of the Secretary of Defense or Deputy Secretary of Defense rather than the Assistant Secretary of Defense for Health Affairs.

Lack of funding may also hamper implementation of MRSP. When MRSP was published, no additional funding was given to responsible program offices for implementing the plan. Although the offices were expected to fund the corrective actions from their ongoing appropriations, many corrective actions were not funded or were only partially funded as of April 30, 1996. Health Affairs officials did not know the amount of these funding shortfalls, but they were planning to assess the impact of the shortfalls in 1997.

Moreover, Health Affairs has limited knowledge regarding the extent to which problems noted in MRSP have been resolved by the corrective actions identified in the implementation plans. Health Affairs is in the process of developing a methodology for making this assessment and plans to begin using it shortly after its completion in March 1997.

Services' Reengineering Programs Offer Improvement

Each service has initiated a medical reengineering program to address shortfalls in medical capabilities. Each reengineering program is at a different stage of development but all are expected to yield enhancements to current system capabilities by making organizational changes, reconfiguring deployable systems, and adapting clinical capabilities to different mission requirements. The services anticipate that these programs will meet their reengineering goals of developing smaller and more mobile systems.

Army

In early 1994, the Army's Surgeon General initiated a medical reengineering program to reconfigure the Army's combat health support operations. This program was to incorporate the lessons learned from

Operation Desert Storm and other operations and reflect the types of combat operations anticipated for the 21st century.

In assessing how its combat health support system should be reconfigured, the Army Medical Command assembled panels of experts for 10 functional areas, such as hospitalization, medical evacuation, and medical logistics. The panels assessed current medical capabilities and proposed organizational and operational changes. The proposed changes are designed to make medical systems modular and more mobile and flexible. Also, the changes are intended to make the systems capable of effectively operating simultaneously in multiple locations and tailored to accommodate missions ranging from intense combat to peacekeeping and humanitarian operations.

Significant changes are proposed for hospital care, which is currently provided in three types of facilities: the Combat Support Hospital, Field Hospital, and General Hospital. The Army is moving toward smaller hospital modules that can provide a full range of services and be self-sufficient and ready for rapid response. One reconfigured 248-bed hospital will replace the 3 current types of hospitals. This new hospital will consist of two self-supporting modules: a mobile 84-bed module and a larger 164-bed module. The 84-bed module will provide increased flexibility because 3 of the modules can be prepositioned aboard a ship and later deployed in separate units if needed. The current Combat Support Hospital must be deployed as a single unit.

The Mobile Army Surgical Hospitals are being phased out. Their mission of providing urgent resuscitative surgery will be assumed by the mobile forward surgical teams, which will perform surgery at locations deeper in the battlefield or closer to the place of wounding. To provide increased flexibility, a medical detachment will be available to augment capability at hospitals throughout the theater. Specialty augmentation teams using the same equipment will be consolidated, and another team will be added to provide capabilities for operations other than war. The proposal also includes improved communications technology, information systems, and use of telemedicine.

In December 1995, the Army's Surgeon General approved the proposed reengineering changes, and they are currently under review by the Army's Training and Doctrine Command, the commanders in chief, and major commands. The changes are expected to be submitted to the Army's Chief of Staff for approval in September 1996. If approved, implementation of

the proposals will begin in fiscal year 2000 and be completed by fiscal year 2005.

Air Force

The Air Force Surgeon General initiated a project in January 1994 to reengineer approaches for delivering medical care during conflicts or other kinds of operations. The initiative consists of three phases: concept development, determination of feasibility, and implementation.

In June 1995, the Air Force Surgeon General approved a new concept that envisions small deployable medical systems to allow commanders more flexibility to tailor their medical care response to a specific mission. Currently, the Air Force generally deploys a 50-bed, surgically intensive, air transportable hospital to a conflict. Under the new concept, more than 40 clinical modules, including general surgery, primary care, intensive care, and dental services, can be deployed individually or in various combinations. According to Air Force officials, the use of a more tailored approach requires less airlift capacity and provides the types of services that are appropriate for a specific mission.

To provide additional mobility and flexibility, the standard air transportable hospital can be scaled down to 25 beds, with an option of deploying a 10-bed trauma clinic to stabilize trauma patients and provide outpatient care. The concept also uses telemedicine to give forward deployed medical personnel the capability to obtain remote consultations in several disciplines, including radiology, dermatology, and pathology.

To evacuate patients more quickly from the theater, the Air Force plans to use critical care aeromedical transport teams to stabilize and evacuate critically ill patients to the United States or other locations for treatment. Each team can be tailored to meet the needs of specific patients, but the teams generally consist of a physician, nurse, and respiratory therapist. The Air Force is testing this concept and has formed seven teams that have transported critically ill patients from Bosnia and Saudi Arabia.

During the summer of 1996, the Air Force realized that its proposed reengineering changes were feasible. As a result, officials have initiated the implementation phase. In addition, the officials were trying to obtain funding through the 1998-2002 Program Objective Memorandum cycle so that the changes could be fully implemented by the end of fiscal year 2002.

Navy

The Navy's fleet hospital reconfiguration project began in the fall of 1995 with the goal of making fleet hospitals lighter and more mobile and mission flexible. Two working groups are involved in the study; one is focusing on reconfiguring fleet hospitals until the year 2010, and the other is focusing on changes in 2010 and beyond.

The first working group developed a preliminary design of a small hospital, but the design has not been approved by Navy leaders. The proposed design, called the Naval Expeditionary Medical Support System, focuses wartime medical capability around a core unit with a capacity of 20 to 130 beds. Although the current 500-bed fleet hospital will be maintained, Navy officials envision that either the 130- or the 500-bed hospital will be set up in a given theater, but not both. In addition, the concept includes an option to extract a 100-bed unit from the standard 500-bed fleet hospital to use during an operation other than war. Under this concept, the Navy will not maintain any duplicate equipment. If the new concept is approved, the fleet hospitals will be repackaged as they are brought in for their periodic modernizing, beginning as early as 1998.

The Navy is also revising its procedures for staffing hospitals. The Navy's requirement for fleet hospitals has decreased from 17 to 12. Six of these hospitals will be staffed primarily by active duty personnel and six will be staffed by reserve personnel. To increase staffing efficiency and productivity, the Navy will now staff its active duty deployable hospitals with personnel from specific medical treatment facilities. In the past, fleet hospitals were staffed by pulling medical personnel from any location, but this approach did not work particularly well in Operation Desert Storm. The revised concept presumes that medical personnel who work together on a day-to-day basis will perform better than staff who are taken from different locations within the system. Similarly, the Navy plans to designate specific reserve units to staff the six reserve component fleet hospitals. Other reserve medical units will be designated to replace active duty staff taken from specific medical treatment facilities.

To ensure that active duty medical personnel earmarked for deployment get the periodic readiness training they need, the Navy designated the executive officers of medical treatment facilities as the commanding officers of the fleet hospitals when they deploy. For reserve medical personnel in units designated to staff fleet hospitals, Navy officials anticipate that the units will train together at a fleet hospital every 2 years. When the reservists do not train at a fleet hospital, they will complete their

annual 2-week training session at a Navy medical treatment facility or at their units' designated hospital.

Marine Corps

In late 1993, the Marine Corps began to reassess the reconfiguration of its medical battalions, which are part of its combat units. The need to reconfigure these battalions grew out of lessons learned from Desert Storm showing that the battalions were too heavy to keep pace with and support the movement of the ground combat units. The Marine Corps found that the capabilities of the medical battalions had been expanded during the Vietnam War era to compensate for the lack of deployable hospitals at higher echelons of care. However, these expanded capabilities were beyond the battalions' mission. The medical supplies and equipment included in each battalion, which should have been assigned to a higher echelon of care, had greatly increased the battalion's weight and size, and hampered its mobility.

The restructuring of the medical battalion essentially reduced those specialty care capabilities that were beyond the mission requirements. This restructuring also placed more reliance on evacuating patients needing such specialty care to higher echelons of care provided by the Navy or other services. In addition, the restructuring reduced the number of cots by 52 percent, from 540 to 260, and reduced the weight of the medical battalion by 20 percent. The new surgical companies within the battalion are staffed with general surgeons and trauma care providers and no longer contain orthopedic and other surgical subspecialties, such as thoracic surgeons. Patients requiring specialty care will be evacuated to other facilities where such care is available. Marine Corps officials believe that the restructured medical battalion, with its decreased lift requirement and smaller footprint, will allow the battalion to move with the combat maneuver elements and provide direct resuscitative health service support to the combat forces.

The Commandant of the Marine Corps approved the restructured medical battalion in November 1995. Two of the four Marine Corps medical battalions have begun implementing the restructuring, and the others will begin reconfiguration by October 1996. Full implementation of the restructuring is expected by the year 2000, assuming funding is available from the Program Objective Memorandum process.

Compatibility of DOD's Future Military Medical System With Current Efforts Is Unknown

In February 1996, Health Affairs began its MHSS 2020 project to forecast changes in health care delivery, with the goal of facilitating the integration of these future health care practices into the design of the military health services system. The project is designed to identify 25-year trends and breakthroughs in both clinical and nonclinical technologies; determine how to apply these technologies across DOD health care responsibilities, which range from personal fitness to treatment of war zone casualties; and identify how the military health services system should be funded and staffed to transition to the year 2020.

Participants in the project include practitioners, researchers, and academicians from several disciplines in the federal and private sectors. The project will involve three stages. First, about 200 experts—organized into 20 specialized working groups concentrating on clinical, administrative, and information management issues—will identify future trends in their fields. Second, 10 multidisciplinary groups will develop strategic planning scenarios for specific areas of military health from the trend information. Third, teams will identify general and specific proposals to help transition the current military health services system from today to the year 2020. DOD expects the future scenarios to be finalized in December 1996.

The MHSS 2020 project could serve as the mechanism for identifying future medical system requirements against which MRSP and the services' reengineering programs should be focused. However, the extent to which MRSP and these reengineering programs will be compatible with future medical system requirements will not be known until the MHSS 2020 project is completed.

Recommendations

We recommend that the Secretary of Defense direct Health Affairs, the Defense Modeling and Simulation Office, and the Office of the Assistant Secretary of Defense for Reserve Affairs to develop and begin implementing plans to correct the medical capability problems noted in MRSP. Without such direction, these offices might continue to give low priority to medical readiness.

We also recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to (1) assess the extent to which actions taken in response to MRSP have corrected medical capability problems, (2) take steps to resolve other unsettled problems, and (3) use

the results of the MHSS 2020 project to guide the focus of MRSP and service reengineering initiatives.

Agency Comments

In commenting on a draft of this report, DOD concurred with our recommendations and agreed with the accuracy of the report. DOD stated that it was aggressively pursuing resolution of the problems described in our report. For example, through Health Affairs/Joint Staff coordination, all of the missing Joint Staff implementation plans have been developed. DOD also commented that Health Affairs has begun the process of assessing the extent to which actions taken in response to MRSP have corrected medical capability problems. From these assessments, DOD will develop strategies for resolution of unresolved problems.

DOD provided some technical comments to our report and we incorporated them into the text of our report where appropriate. DOD's comments appear in appendix I.

Scope and Methodology

To obtain information for the report, we reviewed documents, reports, and information relevant to the development and implementation of MRSP, services' medical reengineering programs, and MHSS 2020 project. We interviewed officials from the Office of the Assistant Secretary of Defense for Health Affairs, Joint Staff and Office of the Assistant Secretary of Defense for Reserve Affairs in Washington, D.C; and the Offices of the Surgeons General at Navy and Air Force Headquarters in Washington, D.C., and at the Army Medical Command in San Antonio, Texas. We also interviewed officials from the U.S. Central Command, Tampa, Florida; U.S. Transportation Command, Scott Air Force Base, Illinois; U.S. Atlantic Command, Norfolk, Virginia, Defense Medical Standardization Board, Fort Detrick, Maryland; and the Marine Corps Combat Development Command, Quantico, Virginia.

We reviewed the methodology used to develop MRSP and discussed its reasonableness with several DOD officials. We compared the content of MRSP with the medical capability problem areas identified in our work on Operation Desert Storm and with similar work conducted by the DOD Inspector General. We reviewed the detailed implementation plans prepared by the primary action offices and identified the extent to which tasks in the plans were reported to be completed, on schedule, or delayed. We did not weigh the relative importance of one task against another. We used the funding status information provided by the primary action

offices. We discussed potential obstacles in implementing MRSP with officials at the locations we visited.

We obtained briefings from all of the services on their medical reengineering programs and reviewed documentation concerning the factors that led to the reengineering efforts, process used to identify needed changes, extent to which the programs address common goals for future medical capabilities, and current status of the reengineering programs. We interviewed agency officials regarding any overlaps or inconsistencies among the services' reengineering programs. We examined the content of each services' reengineering program to learn whether proposed changes were responsive to the problems we and the DOD Inspector General had previously reported for wartime medical capabilities.

We conducted our review from July 1995 to August 1996 in accordance with generally accepted government auditing standards.

We are sending copies of this report to other interested congressional committees; the Secretaries of Defense, the Army, the Navy, and the Air Force; the Commandant of the Marine Corps; and the Director of the Office of Management and Budget. We will also send copies to others on request.

If you or your staff have any questions about this report, please call me on (202)512-5140. Major contributors to this report are listed in appendix II.

Sincerely yours,



Mark E. Gebicke
Director, Military Operations
and Capabilities Issues

Comments From the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

■ 5 SEP 1996

Mr. Mark E. Gebicke
Director, Military Operations and Capabilities Issues
National Security and International Affairs Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Gebicke:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "WARTIME MEDICAL CARE: DOD Is Addressing Capability Shortfalls, but Challenges Remain," dated August 13, 1996 (GAO Code 703104/OSD Case 1204). The DoD generally concurs with the draft report.

DoD is already aggressively pursuing resolution of the problems pointed out by the GAO. For example, through Health Affairs/Joint Staff coordination, all of the missing Joint Staff implementation plans have been developed. Health Affairs has also already begun the process of assessing the extent to which actions taken in response to the Medical Readiness Strategic Plan (MRSPI) have corrected medical capability problems. From these assessments we will develop strategies for resolution of unresolved problems.

Specific DoD comments on the GAO recommendations are provided in the enclosure. Additional technical suggestions were separately provided to the GAO. DoD appreciates the opportunity to comment on the GAO draft report.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen C. Joseph". Below the signature, the name "Stephen C. Joseph, M.D., M.P.H." is printed in a smaller, standard font.

Enclosures:
As Stated

Appendix I
Comments From the Department of Defense

GAO DRAFT REPORT DATED AUGUST 13, 1996
(GAO CODE 703104) OSD CASE 1204

"WARTIME MEDICAL CARE: DOD Is Addressing Capability Shortfalls, but Challenges Remain"

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATIONS

RECOMMENDATION 1: The GAO recommended that the Secretary of Defense direct Health Affairs, the Joint Staff, the Defense Modeling and Simulation Office, the Office of the Assistant Secretary of Defense for Reserve Affairs, and the U.S. Transportation Command to develop and begin implementing plans to correct medical capability problems noted in the Medical Readiness Strategic Plan (MRSP). The GAO observed that without such direction, those offices might continue to give low priority to medical readiness. (p. 12/GAO Draft Report)

DOD RESPONSE: Concur. The DoD is already working to resolve this issue. Health Affairs is working to develop their two missing implementation plans. The Joint Staff, in coordination with Health Affairs has already developed their missing implementation plans. It should be recognized that the U.S. Transportation Command has already submitted all of the required implementation plans.

RECOMMENDATION 2: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to (1) assess the extent to which actions taken in response to the MRSP have corrected medical capability problems and take steps to resolve other unsettled problems, and (2) use the results of the MHSS 2020 project to guide the focus of the MRSP and Service reengineering initiatives. (p. 12/GAO Draft Report)

DOD RESPONSE: Concur. Health Affairs is developing a methodology for assessing the extent to which action taken in response to the MRSP has corrected medical capability problems. This methodology has been tested on one functional area of the MRSP. If successful, the methodology will be applied systematically to the MRSP as a whole.

Enclosure

Major Contributors to This Report

National Security and
International Affairs
Division, Washington,
D.C.

Sharon A. Cekala
Paul L. Francis
Valeria G. Gist
Dade B. Grimes

Norfolk Field Office

Steve J. Fox
Lynn C. Johnson
William L. Mathers
Dawn R. Godfrey